ARC 6625C

HUMAN SERVICES DEPARTMENT[441]

Adopted and Filed

Rule making related to cost report reviews

The Human Services Department hereby amends Chapter 79, "Other Policies Relating to Providers of Medical and Remedial Care," Iowa Administrative Code.

Legal Authority for Rule Making

This rule making is adopted under the authority provided in Iowa Code section 249A.4.

State or Federal Law Implemented

This rule making implements, in whole or in part, Iowa Code section 249A.4.

Purpose and Summary

These amendments were drafted in collaboration with a stakeholder workgroup in response to proposed legislation regarding utilization of generally accepted accounting principles (GAAP) in completion of cost report reviews. These amendments are based on provider feedback and Department analysis of the impact to providers. Changes were made that are a benefit to providers and members and do not require legislation to move forward.

These amendments to the Home- and Community-Based Services (HCBS) Waiver cost reporting requirements are as follows:

- Clarify the programs that submit cost reports.
- Correct Financial and Statistical Report form numbers.
- Remove the 20 percent limitation from all HCBS salary, benefit and payroll tax expenses.
- Retain, with no changes, the current limitation on all other HCBS expenses.
- Change the mileage reimbursement for business use of personal employee vehicles to be reimbursed according to the federal Internal Revenue Service's (IRS's) published mileage rate.
- Change the cost reporting period to align with the provider's fiscal year.
- Set the maximum allowed compensation for the executive director, corporate executive officer, or equivalent position, who is an owner or immediate relative, equal to the intermediate care facility for persons with an intellectual disability maximum compensation for facilities with 60 beds or more pursuant to subparagraph 82.5(11)"e"(4). Currently this is limited by the 20 percent limitation on wages, benefits and taxes.
- Provide definitions for the terms reasonable and necessary, related party, ownership, and control.
- Add rebasing language for recalculation of rates every three years for HCBS brain injury (BI) waiver supported community living services; HCBS children's mental health waiver family and community support services; and interim medical monitoring and treatment services when provided by an HCBS-certified supported community living services agency to be consistent with intellectual disability (ID) waiver rebasing.

Public Comment and Changes to Rule Making

Notice of Intended Action for this rule making was published in the Iowa Administrative Bulletin on August 24, 2022, as **ARC 6475C**. No public comments were received. No changes from the Notice have been made.

Adoption of Rule Making

This rule making was adopted by the Council on Human Services on October 13, 2022.

Fiscal Impact

This rule making could potentially increase the amount of reportable costs for the following services:

- ID Waiver Supported Community Living (15-minute unit).
- BI Waiver Supported Community Living (15-minute unit).
- BI Waiver Supported Community Living (daily unit).
- Community Mental Health (CMH) Waiver Family and Community Support Services.
- Interim Medical Monitoring and Treatment for the BI, Health and Disability (HD), and ID waivers.

An increase in reportable costs could increase Medicaid provider rates. The prospective rates for established providers are capped at the upper rate limits in subrule 79.1(2). Across these services, there are currently 134 of 238 providers paid below the upper rate limit. It is unclear by how much provider rates will increase because of these amendments. A high-end estimate assumes rates for all 134 providers will increase to the upper limit as a result of these amendments. A low-end estimate assumes no providers experience an increase to current rates. The fiscal estimate is based on the midpoint of these two scenarios. Assumptions used to calculate the fiscal impact are based on the number of providers not currently paid at maximum rates relative to state fiscal year 2020 fee-for-service utilization. A midpoint estimate was used. It is estimated that the impact would be approximately $300,000 total; the state-only fiscal impact would be $100,000. This fiscal analysis is only based on fee-for-service utilization. The managed care organizations (MCOs) and the providers must negotiate the providers' reimbursement rates.

Jobs Impact

After analysis and review of this rule making, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rule making would result in hardship or injustice to that person may petition the Department for a waiver of the discretionary provisions, if any, pursuant to rule 441—1.8(17A,217).

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rule making by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rule making at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

Effective Date

This rule making will become effective on January 1, 2023.

The following rule-making actions are adopted:

ITEM 1. Amend subparagraph **79.1(1)"e"(3)** as follows:

(3) The prospective rates paid to both new and established providers are subject to the maximums listed in subrule 79.1(2) and to retrospective adjustment ~~based on the provider's actual, current costs of operation as shown by financial and statistical reports submitted by the provider, so as not to exceed reasonable and proper costs actually incurred by more than 4.5 percent.~~ pursuant to paragraph 79.1(15)*"f."*

ITEM 2. Amend subrule 79.1(15), introductory paragraph, as follows:

79.1(15) *HCBS retrospectively limited prospective rates.* This methodology applies to reimbursement for HCBS brain injury waiver supported community living; HCBS intellectual disability waiver supported community living for 15-minute services; HCBS children's mental health waiver

family and community support services; and HCBS interim medical monitoring and treatment when provided by an HCBS-certified supported community agency under an HCBS intellectual disability waiver, brain injury waiver, or health and disability waiver.

ITEM 3. Rescind paragraph **79.1(15)"a"** and adopt the following **new** paragraph in lieu thereof:

a. Reporting requirements.

(1) Providers shall submit the complete Form 470-5477. The provider shall email the report and required supplemental information to costaudit@dhs.state.ia.us. The provider shall mail one signed copy of the certification page to the Iowa Medicaid Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, no later than the due date of the required electronic submissions.

(2) Regardless of the period for the provider's fiscal year, the provider shall submit a financial and statistical report for the period of July 1, 2021, through June 30, 2022. For provider fiscal periods beginning on or after July 1, 2022, the provider shall submit a financial and statistical report coinciding with the provider's fiscal year.

(3) The provider shall submit the financial and statistical report on or before the last day of the third month following the end of the cost reporting period.

(4) A certified home health agency enrolled to deliver HCBS that is required to submit a Medicare cost report may request a 60-day extension for submitting the financial and statistical cost report. All other providers may request a 30-day extension for submitting the financial and statistical report. All requests must be submitted in writing to the Iowa Medicaid provider cost audit and rate setting unit by the financial and statistical report due date. No other extensions will be granted.

(5) If a provider terminates its participation in any HCBS program or service, the provider shall submit a final financial and statistical report on or before the sixtieth day following the date of termination for retrospective adjustment in accordance with subparagraph 79.1(15)*"f"*(1).

(6) Providers failing to submit a financial and statistical report that meets the requirements of this paragraph within the time frames set forth in subparagraph 79.1(1)*"a"*(3) or 79.1(1)*"a"*(4), as applicable, shall reduce payment to 76 percent of the current rate. The reduced rate shall be paid for not longer than three months, after which time no further payments will be made.

(7) Providers shall submit a completed financial and statistical report in an electronic format that can be opened using the extension xls or xlsx. The provider shall submit supplemental documentation in a generally accepted business format.

(8) Along with its financial and statistical report, the provider shall include a working trial balance that corresponds to the data contained on the financial and statistical report. Financial and statistical reports submitted without a working trial balance will be considered incomplete.

(9) The provider's financial data within the financial and statistical report shall be based on the provider's financial records. When the records are not based on the accrual basis of accounting, the provider shall make adjustments necessary to convert the information to an accrual basis for reporting.

(10) Providers of multiple programs or services shall submit a cost allocation schedule. The schedule must identify an allocation method for each expense account, including the statistics used in the calculation.

(11) Providers shall not report costs to any waiver service that are costs of any other program or public or private funding sources, including but not limited to the Medicaid state plan; Medicare; other state, local or federal funded programs; and private funding sources. Providers shall not report costs of HCBS waiver services as a cost of any other public or private funding source.

(12) Iowa Medicaid or its designee may review or audit financial and statistical reports as filed to determine the actual cost of services in accordance with generally accepted accounting principles or Medicare cost principles published in Centers for Medicare and Medicaid Services Publication §15-1, subject to the exceptions and limitations in the department's administrative rules and financial and statistical report instructions.

(13) Failure to maintain records to support the financial and statistical report and make them available to the department or its designee upon request may result in adjustment, payment reduction, or sanction including but not limited to termination of the provider's HCBS certification.

(14) When adjustments made to prior reports indicate noncompliance with reporting instructions or the provider has a history of inadequate documentation to support the financial and statistical report, the department may require that an external accountant experienced with cost report preparation prepare the financial and statistical report or that a certified public accountant complete a review or examination of the financial and statistical report or cost allocation methodology.

ITEM 4. Rescind paragraph **79.1(15)"b"** and adopt the following **new** paragraph in lieu thereof:

b. Home- and community-based general rate criteria.

(1) To receive reimbursement for services, a certified provider shall enter into an agreement with the department on Form 470-2918 and have an approved service plan for the member.

(2) The rates a provider may charge are subject to limits established in subrule 79.1(2).

(3) Twenty percent identified cost limitation.

1. The following identified costs are not subject to the 20 percent limitation; however, the following costs are used to calculate the limitation:

- Wages, benefits, and payroll taxes.
- Direct care transportation expense—with and without member present.
- Direct care development, training, and supplies.
- Member-specific assistance.
- Member-specific equipment repair or purchase.

2. For each waiver service, the sum of reported costs not identified in numbered paragraph 79.1(15)*"b"*(3)"1" is limited to 20 percent of the identified costs in numbered paragraph 79.1(15)*"b"*(3)"1."

(4) Mileage reimbursement for business use of personal employee vehicles shall be limited to the federal Internal Revenue Service's (IRS's) published mileage rate in effect during the cost reporting period.

(5) Compensation for services of owners or immediate relatives is an allowable cost, provided the services are actually performed in a necessary function and do not exceed the maximum allowed compensation as described in numbered paragraphs 79.1(15)*"b"*(5)"5" and "6."

1. "Ownership" is defined as an interest of 5 percent or more. For this purpose, the following persons are considered immediate relatives: husband, wife, natural or adoptive parent, natural or adoptive child, natural or adoptive sibling, step-parent, step-child, step-sibling, parent-in-law, child-in-law, sibling-in-law, grandparent, or grandchild. Adequate time records shall be maintained.

2. "Compensation" means the total benefit received by the owner or immediate relative for services rendered. Compensation includes all remuneration, paid currently or accrued, for managerial, administrative, professional and other services rendered during the period. Compensation shall include all items that should be reflected on IRS Form W-2, Wage and Tax Statement, including but not limited to salaries, wages, and fringe benefits; the cost of assets and services received; and deferred compensation. Fringe benefits shall include but are not limited to costs of leave, employee insurance, pensions and unemployment plans. If the facility's fiscal year end does not correlate to the period of the W-2, a reconciliation between the latest issued W-2 and current compensation shall be required to be disclosed to Iowa Medicaid or its designee. Employer portions of payroll taxes associated with amounts of compensation that exceed the maximum allowed compensation shall be considered unallowable for reimbursement. Providers shall report all compensation paid to related parties, including payroll taxes, on the financial and statistical report.

3. "Reasonableness" requires that the compensation allowance be such an amount as would ordinarily be paid for comparable services by comparable providers, and depends upon the facts and circumstances of each case.

4. "Necessary" requires that the function be such that had the owner or immediate relative not rendered the services, the facility would have had to employ another person to perform the service, and be pertinent to the operation and sound conduct of the institution.

5. The maximum allowed compensation for the executive director, corporate executive officer, or equivalent position, who is an owner or immediate relative, is equal to the intermediate care facility

for persons with an intellectual disability maximum compensation for facilities with 60 beds or more pursuant to 441—subparagraph 82.5(11)*"e"*(4).

6. The maximum allowed compensation for any other owner or immediate relative is 60 percent of the amount allowed in numbered paragraph 79.1(15)*"b"*(5)"5."

7. The provider shall maintain records in the same manner for an owner or immediate relative compensated by the agency as are maintained for any employee of the agency, including but not limited to employment records, timekeeping, and payroll records.

8. The maximum allowed compensation for owners and immediate relatives shall be adjusted by the percentage of the average workweek devoted to business activity during the fiscal year of the financial and statistical report. The time devoted to the business shall be disclosed on the financial and statistical report. If an owner's or immediate relative's time is allocated to the facility from another entity (e.g., home office), the compensation limit shall be adjusted by the percentage of total costs of the entity allocated to the facility. In no case shall the amount of salary for one owner or immediate relative allocated to multiple facilities be more than the maximum allowed compensation for that employee had the salary been allocated to only one agency.

9. Costs applicable to services, facilities, and supplies furnished to the provider by a person or organization related to the provider by common ownership or control are a reimbursable cost when included at the cost to the related party or organization. The cost shall not exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere.

- "Related" means that the agency, to a significant extent, is associated with or has control of or is controlled by the organization furnishing the services, facilities, or supplies.
- Common ownership exists when an individual or individuals possess significant ownership or equity in the facility and the institution or organization serving the provider.
- Control exists where an individual or an organization has power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution.
- A provider may lease a facility from a related person or organization. In such case, the rent paid to the lessor by the provider is not allowable as a cost. The provider, however, would include in its cost the costs of ownership of the facility. This includes depreciation, interest on the mortgage, real estate taxes, and other expenses attributable to the leased facility.
- An exception is provided to the general rule applicable to related organizations. The exception applies if the provider demonstrates by convincing evidence that the criteria in numbered paragraph 79.1(15)*"b"*(5)"10" have been met.

10. The agency must demonstrate the following with convincing evidence. Where all of the conditions below are met, the charges by the supplier to the provider for such services, facilities, or supplies are allowable as costs.

- The supplying organization is a bona fide separate organization;
- A substantial part of its business activity of the type carried on with the facility is transacted with others and there is an open competitive market for the type of services, facilities, or supplies furnished by the organization;
- The services, facilities, or supplies are those which commonly are obtained by similar institutions from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by the institutions; and
- The charge to the agency is in line with the charge for services, facilities, or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for the services, facilities, or supplies.

ITEM 5. Rescind paragraph **79.1(15)"c"** and adopt the following **new** paragraph in lieu thereof:

c. Prospective rates for new providers.

(1) "New providers" means providers who have not submitted an annual report including at least six months of actual, historical costs of operations for any service as listed in subrule 79.1(15).

(2) New providers shall be paid prospective rates based on projected reasonable and proper costs of operation for a 12-month period.

(3) Projected costs of any new service, as listed in subrule 79.1(15), shall be submitted on Form 470-5477.

(4) Prospective rates shall be subject to retrospective adjustment as provided in paragraph 79.1(15)*"f."*

(5) After a provider has submitted an annual report including at least six months of actual, historical costs, prospective rates shall be determined as provided in paragraph 79.1(15)*"d."*

ITEM 6. Rescind paragraph **79.1(15)"d"** and adopt the following **new** paragraph in lieu thereof:

d. Prospective rates for established providers.

(1) "Established providers" means providers who have submitted an annual report including six months of actual, historical costs of operation.

(2) The prospective rate will be adjusted annually, effective the first day of the third month after the month during which the annual financial and statistical report is submitted to the department.

(3) The provider's prospective rate shall be the lower of:

1. The provider's reasonable and proper actual cost-based rate as calculated by the provider's most recent financial and statistical report and adjusted by the consumer price index for all urban consumers for the preceding 12-month period ending as of the provider's fiscal year end,

2. In the first year of reporting six months of actual, historical costs of operation, or a year in which the provider's base rate is recalculated, the base rate is equal to the amount calculated in numbered paragraph 79.1(15)*"d"*(3)"1,"

3. In a year in which the provider's base rate is not recalculated, the prior period base rate adjusted by the consumer price index for all urban consumers for the preceding 12-month period ending as of the provider's fiscal year end, or

4. The upper rate limit pursuant to subrule 79.1(2).

(4) Recalculation of base rates (rebasing).

1. For providers of HCBS brain injury waiver supported community living services; HCBS children's mental health waiver family and community support services; and interim medical monitoring and treatment services when provided by an HCBS-certified supported community living services agency, the base rates will be recalculated based on the reasonable and proper actual costs of operation as calculated by the fiscal year 2022 financial and statistical report.

2. For providers of HCBS brain injury waiver supported community living services; HCBS children's mental health waiver family and community support services; interim medical monitoring and treatment services when provided by an HCBS-certified supported community living services agency; and 15-minute HCBS intellectual disability waiver supported community living services, the base rates will be recalculated based on the reasonable and proper costs of operation for the provider's fiscal year ending on or after January 1, 2024.

3. Subsequent to the recalculation of base rates in numbered paragraph 79.1(15)*"d"*(4)"2," a provider's base rate shall be recalculated no less than every three years.

(5) Prospective rates shall be subject to retrospective adjustment as provided in paragraph 79.1(15)*"f."*

ITEM 7. Amend paragraph **79.1(15)"f"** as follows:

f. Retrospective adjustments.

(1) ~~Retrospective~~ For fee for service, retrospective adjustments shall be made based on reconciliation of provider's reasonable and proper actual service costs with the revenues received for ~~those services as reported on Form 470-3449, Supplemental Schedule, accompanying Form SS-1703-0, Financial and Statistical Report for Purchase of Service~~ 15-minute HCBS intellectual disability waiver supported community living services; HCBS brain injury waiver supported community living services; HCBS children's mental health waiver family and community support services; and interim medical monitoring and treatment services when provided by an HCBS-certified supported community living services agency under an HCBS intellectual disability waiver, brain injury waiver, and health and disability waiver, as reported on Form 470-5477, subject to the upper rate limit allowed in subrule 79.1(2).

~~(2) For services provided from July 1, 2015, through June 30, 2016, revenues exceeding adjusted actual costs by more than 4.5 percent shall be remitted to the department. Payment will be due upon notice of the new rates and retrospective rate adjustment.~~

~~(3) For services provided from July 1, 2015, through June 30, 2016, providers who do not reimburse revenues exceeding 104.5 percent of actual costs 30 days after notice is given by the department will have the revenues over 104.5 percent of the actual costs deducted from future payments.~~

~~(4)~~ (2) For services provided on or after July 1, 2016, revenues exceeding adjusted actual costs by more than 5.5 percent for fee for service shall be remitted to the department. Payment will be due upon notice of the new rates and retrospective rate adjustment.

~~(5) For services provided on or after July 1, 2016, providers who do not reimburse revenues exceeding 105.5 percent of actual costs 30 days after notice is given by the department will have the revenues over 105.5 percent of the actual costs deducted from future payments.~~

(3) If a provider does not remit the amount of the overpayment identified in subparagraph 79.1(15)*"f"*(2) within 30 days after notice, the department will deduct the amount owed from future payments.

ITEM 8. Rescind paragraph **79.1(15)"g."**

[Filed 10/13/22, effective 1/1/23]
[Published 11/2/22]

EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 11/2/22.